GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CASE PROGRESS REPORT

❑ **Initial** ❑ **Supplement** ❑ **Final** ❑ **Reopened**

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury

A. IDENTIFYING INFORMATION

	Name	Insurer /Self Insurer File Number	SBWC ID# (five digit no.)	Date of Final Weekly Payment
EMPLOYER				

B. PAYMENT TYPE Enter actual amounts paid	RATE	WEEKS	DAYS	TOTAL PAYMENTS
❑ (a) Temporary Total				
❑ (b) Temporary Partial				
❑ (c) Permanent Partial				
❑ (d) Death				
❑ (e) Stipulation/Settlement				
❑ (f) Advances				

	C. PAYMENTS	TOTAL LOST TIME PAYMENTS TO DATE
1	Total Weekly Benefits	
2	Physician Benefits	
3	Hospital Benefits	
4	Pharmacy Benefits	
5	Physical Therapy	
6	Chiropractic	
7	Other (Medical)	
8	Rehabilitation / Vocational (excluding all of the above)	
9	Late Payment Penalties	
10	Assessed Attorney's Fees	
11	Burial	
	Totals	

D. Recovery code: ❑ for Subrogation ❑ for Overpayment ❑ for SITF ❑ Other

Remarks

E. ❑ I certify that the total payments are as correct as the available information indicates.

Type or Print Name		Signature		Date
Address			E-mail	
City	State	Zip Code	Phone Number	
Insurer/Self Insurer Name		Claims Office Name		

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).